IMMUNIZATION RECORD - CHILD AND YOUTH PROGRAMS

(CDC/CDH only/not required for SAC)

CHILD'S NAME *(LAST, FIRST, M.I.)*:	SEX: ☐ MALE ☐ FEMALE
SPONSOR'S SOCIAL SECURITY NUMBER:	DATE OF BIRTH *(DAY/MONTH/YEAR)*:

TO BE COMPLETED BY IMMUNIZATION STAFF

CHILD'S AGE	IMMUNIZATION DUE	DATE GIVEN
BIRTH-2 MONTH	HEPATITIS B #1	
2-4 MONTHS	HEPATITIS B #2	
2 MONTH	DTaP/DTP #1	
	IPV/OPV #1	
	PCV #1	
	Hib #1	
4 MONTHS	Hib #2	
	DTaP/DTP #2	
	IPV/OPV #2	
	PCV #2	
6 MONTHS	Hib #3	
	DTaP/DTP #3	
	PCV #3	
6-18 MONTHS	HEPATITIS B #3	
	IPV/OPV #3	
12-15 MONTHS	Hib #4	
	MMR #1	
	PCV #4	
12-18 MONTHS	VARICELLA	
15-18 MONTHS	DTaP/DTP #4	
4-6 YEARS	MMR #2	
	DTaP/DTP #5	
	IPV/OPV #4	

CERTIFICATION: REQUIRED IMMUNIZATIONS FOR CHILD'S ENROLLMENT HAVE BEEN COMPLETED.

NOTES: THE ABOVE NAMED CHILD HAS BEEN GIVEN A ROUTINE MEDICAL EXAMINATION AND HAS BEEN FOUND FREE OF INFECTIOUS OR CONTAGIOUS DISEASES, AND CAPABLE OF PARTICIPATING FULLY IN CHILD AND YOUTH PROGRAMS WITH THE EXCEPTIONS LISTED:

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DATE: _____

PRINT AUTHORIZED MEDICAL PERSONNEL'S SIGNATURE:

AUTHORIZED MEDICAL PERSONNEL'S SIGNATURE:

NAME OF CLINIC: